EUI WORKING PAPERS IN LAW

EUI Working Paper LAW No. 94/2

The British Abortion Act (1967) A Permissive Reform?

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EUROPEAN UNIVERSITY INSTITUTE, FLORENCE

DEPARTMENT OF LAW

EUI Working Paper **LAW** No. 94/2

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Printed in Italy in April 1994
European University Institute
Badia Fiesolana
I – 50016 San Domenico (FI)
Italy

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The British Abortion Act (1967) - A Permissive Reform?[1]

Sally Sheldon

Permissive: "Having the quality of permitting or giving permission; that allows something to be done or to happen; not forbidding or hindering. In modern use freq.: tolerant, liberal, allowing freedom, spec. *in sexual matters; freq. in phr.* permissive *society." (Oxford English Dictionary).*

"One example has been given to me by a general practitioner of a girl, unmarried, and, therefore, one of the minority of cases of illegal abortion, who came to him about two or three months ago, said she was pregnant, and that she wished to have her pregnancy terminated...She said to him that she had come because of the Bill. "I believe that I have grounds under that", she said. He told her, "I happen to know the sponsor of the Bill. I have looked at the Bill and do not think that under it you have grounds." He talked to the girl and put her in touch with people who could help her. Her pregnancy is now going through in the normal way. It does not follow that because women desire termination it will automatically be carried out. If we can manage to get a girl such as that into the hands of the medical profession, the Bill is succeeding in its objective. If the Bill had not been before Parliament, if the girl had thought that what she sought was something illegal and was not to be talked about, and had, therefore not gone to the doctor, she might have had the baby after nine months of great anxiety: she might, as often happens have taken some substance, or have inflicted some injury upon herself which might have aborted the baby, admitted her to hospital to take up time in a gynaecological bed, and, possibly, have left her with a permanent injury. Worse than that, she might have been driven to the desperate situation of committing suicide. Worst of all, she might have been among the statistics of the average of 30 women a year who die of operations at criminal hands. None of those things happened, because she thought she would get a good hearing from that doctor. If the Bill encourages that kind of climate, it will have been worthwhile"[2].

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[1] I would like to thank Eugene MacNamee and Gunther Teubner for their comments on an earlier draft of this paper.

[2] David Steel, on presenting the Medical Termination of Pregnancy Bill (which was to become the *Abortion Act*) for its third reading in the House of Commons, H.C. Deb. Vol. 750, Col. 1349, 1967 (13 July).

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Introduction

"The 1960s saw a tidal wave of permissive indulgence, homosexual as well as heterosexual. One-parent families, a huge boom in contraceptives, a crusade for sexual indulgence in whatever form, became accepted" (Morgan in Thompson; 1993; 137).

If there is something novel about the title of this paper, it is probably nothing more than the way which I have chosen to punctuate it - ending it with a question mark rather than a full stop. To describe the 1967 *Abortion Act* as permissive seems little more than common sense. It is received knowledge that the *Abortion Act* represented a liberalisation of the previous law, taking English statute from a near blanket ban on the performance of abortions, to a system whereby terminations might be performed in certain circumstances given the approval of two doctors. Thus it would seem self-evident that the *Abortion Act* must be permissive in the sense that it decreased repressive criminal controls and facilitated a greater degree of individual (especially female) autonomy in sexual and reproductive matters. Henceforth, it seems, a woman would be guaranteed a greater degree of privacy, autonomy and freedom in her decision to terminate a pregnancy. The vast majority of commentators, regardless of their opinion of the desirability or acceptability of the *Abortion Act*, have accepted this interpretation (Lapping; 1970, Davies; 1975).

Moreover, this vision of the *Abortion Act* as a permissive measure fits neatly into a powerful and dominant story which has been told about the late 1960s in the UK. The latter half of the 'Swinging Sixties' are remembered not only for their permissive social mores, but also for the influence of these values on social policy, and the introduction of increasingly liberal, permissive legislation and humanising reform. A Labour government, headed by Harold Wilson, was voted into power in 1964, and having secured a larger majority of seats in 1966, it embarked on a substantial programme of social reform. The voting age was lowered to 18 (1969), divorce was made easier (1969), access to contraception was facilitated (1967), the death penalty was largely abolished (1965-9), a more liberal attitude was taken towards the censorship of plays (1968) and homosexuality was decriminalised, albeit in very restricted circumstances (1967). These reforms have been described in extravagant terms. Christie Davies (1975), for example, assesses such measures as signalling a shift to a new and more permissive Britain. The reform of the

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legislation governing abortion was a central piece of this programme[3] and the dispute over abortion reform was cast in this light, becoming constructed as a contest between enlightenment and obscurantism. The *Abortion Act* was heralded as the victory of 'forward looking minds over the prisoners of the past'[4], as a crucial step in the process of women's emancipation[5], and as a permissive measure which liberalised, humanised and modernised the previous law.

This construction of the *Abortion Act* as permissive has been a starting point for both the liberal approbation and the conservative criticism which greeted its passing. Conservative fears of the likely result of the liberalisation of abortion law were expressed as long ago as 1939, when the Birkett Committee (an inter-departmental committee appointed by the Minister of Health) had concluded that abortion should be available only on medical grounds. To provide it at the woman's request would only aggravate the disturbing trend of the decline in the birth rate and "prove an added temptation to loose and immoral conduct" (Brookes; 1988; 125). This sentiment was still very much present in the late 1960s. Paul Ferris wrote in his book, *The Nameless*, published the year before the *Abortion Act* was passed: "one often meets the feeling that abortion,

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[3] Although the *Abortion Act* results from a Private Member's Bill introduced by a young, Liberal MP, David Steel, it is clear that it could never have succeeded without Government help. This was provided, firstly in the form of drafting assistance and, secondly and more importantly, the granting of extra Parliamentary time. Between 1952 and 1967 there had been five attempts to reform the law (see note 9 below), all of which had been talked out and failed for lack of time.

[4] The first Abortion Law Reform Association conference found that abortion was not a struggle between women and men, but between "the prisoners of the past and forward looking minds" (ALRA Conference, 15 May, 1936, in Brookes (1988; 95)).

[5] Price, H.C. Deb Vol. 750 Col. 1372, 1967 (13 July). Here again the AA seems to fit in with other contemporary measures. The *Matrimonial Property Act* laid down that women's work whether inside or outside of the home should be considered as a contribution towards buying the family assets, when they came to be divided on divorce. The *Equal Pay Act* (1970), introduced by Barbara Castle during her time as Secretary of State for Employment and Production, laid down the principle of same wages for same work. The *Divorce Act* (1969) established the right of a couple to have a divorce after two years apart where both partners wanted it, or five years' separation where one partner did not agree. The *Family Planning Act* (1967) provided for the provision of family planning facilities on the NHS.

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like contraception, is the thin end of a decadent wedge, a dangerous device to make sex easy for all. The trouble with protectives (says this argument) is that they can be bought by promiscuous bachelors as well as by prudent husbands. Similarly, even those who favour a more liberal attitude to abortion may be inhibited by the thought that any conceivable system short of one founded on explicit moral sanctions, can be used by tarts as well as by tired housewives" (1966; 10-11)[6].

Others, however, welcomed the perceived permissive character of the reforms. Brian Lapping purports to identify a common theme running throughout a great many of the "civilising measures" introduced during these years: the right to privacy. He writes that "[t]he Abortion and Family Planning Acts sought to ensure the right to privacy of a man and a woman who chose to make love. If they did not want to seek the public acknowledgement and approval of their conduct, called for by having a baby, these new measures helped to protect their privacy" (1970; 218). These years are remembered by liberals as ushering in an age of permissiveness, and hence a new degree of human liberty, for as Benjamin Disraeli said: "permissive legislation is the characteristic of a free people" (Davies; 1975; 13).

It seems to me that this citation from Disraeli may provide a useful heuristic device for outlining the argument which I wish to make in this paper. I will claim that it is the logic of this statement which also underlies this story about the *Abortion Act*. If Disraeli is to be believed, then it seems self-evident that the restriction of criminal controls over abortion was characteristic of a newfound freedom for women. However, it seems to me that in Disraeli's statement, as in this account of the *Abortion Act*, freedom emerges as no more than a space for action created by the absence or limitation of repressive (criminal) legislation. One is free only in the sense of being free from one particular manifestation of (repressive) power which emanates from the State; other forms of power are ignored and no room is left for analysis of the *quality* of the

[6] In introducing her (failed) reform bill in 1965, Renée Short was careful to refute any correlation between liberalisation of abortion and an increase in promiscuity, H.C. Deb. Vol. 714, Col. 254, 1965 (15 June). However, many MPs still posited connections between the two, e.g. William Deedes, H.C. Deb. Vol. 732, Col. 1092, 1966 (22 July).

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freedom which one may exercise. My opening citation, taken from the Parliamentary debates leading to the introduction of the 1967 Act, reveals another aspect of its introduction - the desire to bring women seeking termination under closer control: to bring them into contact with doctors, and a more subtle, decentralised form of power.

Before going any further, however, I should set out in more detail exactly what I mean by 'permissive'. A "permissive" measure is one which permits or tolerates certain behaviour, which limits the potential of external bodies to intervene in the life of an individual to correct or to punish certain acts, especially in sexual matters. Further, here I am taking "permissive" as having the more specific meaning of describing something which loosens control over sexuality and reproduction, and which contributes to the constitution of a 'private' sphere where sex (and its potential reproductive consequences) can be enjoyed free from external interference, regardless of the (lack of) procreative intention of the participants. The aim of this paper will be to assess how far the *Abortion Act* fits within this definition, and thus how far it can be seen as heralding a newfound freedom for women.

In this paper I will adopt a more expansive view which sees power not merely (or indeed primarily) as a repressive force deployed by various central institutions, but rather as diffuse, productive and capillary, as a "complex strategical situation", or omnipresent "multiplicity of force relations" (Foucault; 1990; 92-7). One particular benefit of this model is that whilst not denying the existence of central loci of power, it redirects attention away from centralised and legitimate forms of power and focuses more on techniques which have become embodied in local, regional material institutions (Foucault; 1980b; 97), here particularly on medical practices[7].

[7] My aim here is not be to deny the importance of the State - indeed a central focus of the analysis of this chapter will be the mapping of State attempts to gain control over abortion. However, I do want to oppose the idea that power *derives* from the State. As Michel Foucault has said: "the state is not simply one of the forms or specific situations of the exercise of power...in a certain way all forms of power relation must refer to it...not because they are derived from it;...rather because power relations have come more and more under state control...that is to say elaborated, rationalized, and centralized in the form of, or under the auspices of, state institutions" (1982; 224). One theme of this chapter will be a mapping of State attempts to bring

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One final precision that I must make is that I feel it to be necessary to distinguish between the *aims* of the legislation and its *effects* in practice. There is undoubtedly a wide gulf between these two levels, however, I would contend that on both of these to view the *Abortion Act* as a permissive measure which decreases the deployment of power over women is a highly partial vision of the legislation. In this paper, I shall be focussing on the aims of the legislation. Here, I seek to give an account of the partial decriminalisation of abortion in the UK in the 1967 *Abortion Act*, and to examine the arguments expressed in favour of reform. Emphasis is placed on the Parliamentary debates preceding the introduction of the *Abortion Act*. As I have argued elsewhere (Sheldon; 1993; 5), such debates have a particularly important role as 'telling instances' of predominant social discourses. I will begin by (briefly) sketching the background to the *Abortion Act* by way of an overview of the development of the law and medical practices until 1967 (section 1), before going on to an assessment of the reasons presented for reform - the problems that the Act aimed to address (section 2). My claim here is that the *Abortion Act* was actually a measure which was largely motivated by a desire to facilitate a closer control over the 'private' sphere, rather than one which sought to delineate a space for autonomous female action. In a third section, I take a fresh look at the form of the regulation which the *Abortion Act* introduces in the light of the preceding analysis (section 3), before going on in a final section to present some tentative conclusions (section 4).

1. The Development of the Law until 1967: "A Reform Whose Time Had Come" [8]

a) Statute law

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existing the pre-existing medical control of abortion under its own control.

[8] This is how Madeleine Simms of the Abortion Law Reform Association (ALRA) described the AA (1985; 83).

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Abortion was an area where reform seemed long overdue. Inside and outside of Parliament, there was widespread desire for change and modernisation. Indeed in the 15 years preceding the introduction of the *Abortion Act* 1967, there had been no fewer than five parliamentary initiatives aiming at reform[9]. The *Offences Against the Person Act*, 1861, which governed the regulation of abortion, was widely criticised as anachronistic and archaic. It provides that:

s.58 Every woman being with child, who, with intent to procure her own miscarriage shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony...

s.59 Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanor...

These sections contain no time limit, make no distinction between abortions early and late in pregnancy[10] and include no explicit exception for therapeutic abortion. A time limit was later read into the *Offences Against the Person Act* by virtue of the *Infant Life (Preservation) Act*

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[9] The attempts at reform were introduced by Joseph Reeves MP (House of Commons, 1952); Lord Amulree (House of Lords, 1954); Kenneth Robinson (House of Commons, 1961); Reneé Short (House of Commons, June 1965); Lord Silkin (House of Lords, November 1965). For more discussion of these initiatives, see Dickens (1966; 123-31).

[10] Previously English law had distinguished between abortion before and after quickening. This had been the position in common law, and was enshrined in statute in the first statute regulating abortion, *Lord Ellenborough's Act* (42 Geo. III. c.58) in 1803, which made abortion a felony in the case of abortion after quickening, but only a misdemeanour where it occurred before quickening. The distinction was removed by the *Offences Against the Person Act*, 1837, which established the substantial form of the modern law (see Smith and Hogan; 1988; 366). Quickening was the point at which the foetus was believed to become ensouled i.e. when the soul entered the body. It also marked the point when the woman might feel the first stirring inside her. Quickening was believed to occur at around 12 weeks, although this was believed to be earlier for a male foetus than a female one.

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1929. This Act had not been introduced in order to deal with abortion. Rather it was intended to close a legal loophole, revealed in a observation by Talbot J. at Liverpool Assizes[11], whereby the killing of the foetus/baby in the actual process of being born was covered neither by the *Offences Against the Person Act* (which foresaw an offence only where miscarriage was procured) nor by the law of murder. Thus, where a baby was killed during the process of (spontaneous) birth, but before being fully separated from the body of the pregnant woman, no offence was committed. The *Infant Life (Preservation) Act* introduced the offence of child destruction, s.1(1) prohibiting the destruction of a child capable of being born alive, making an exception only for the case where its destruction was carried out in good faith for the purpose of preserving the life of the pregnant woman[12]. The Act included a rebuttable presumption that this capacity for life was acquired at 28 weeks of gestation. This limit was read into the *Offences Against the Person Act* (and later the *Abortion Act*) as prohibiting abortion after this time, except where the additional requirements of the *Infant Life (Preservation) Act* were also fulfilled[13].

b) Medical practice and jurisprudence

However, the availability of abortion prior to 1967 was not so restricted in practice as it might have appeared on paper. There had long been room for manoeuvre by medical practitioners in the performance of abortions and the decision in *R v Bourne* (1938)[14] had given explicit judicial approval to the exercise of medical discretion for therapeutic terminations. Dr Bourne had aborted a girl of fifteen who had been raped by a group of soldiers. He defended himself on grounds of good medical practice, rather than basing his case on an appeal to humanity, asserting

[11] Cited by Lord Darling in the House of Lords debate (see Grubb; 1990; 149).

[12] A second purpose of the Act was to legalise the operation of craniotomy - crushing the impacted foetal skull, inevitably causing foetal death - which was widely practised to save the life of the pregnant woman, before caesarian section became commonplace.

[13] The *Abortion Act* and *Infant Life (Preservation) Act* were explicitly 'uncoupled' by s.37(4) of the *Human Fertilisation and Embryology Act* (1990).

[14] [1938] 3 All ER 615.

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that the girl's mental and physical health might have suffered had the pregnancy continued. Macnaghten J., who presided over the case, linked the 1861 and 1929 statutes, and ruled that the burden rested on the crown to satisfy the jury that the defendant did not procure the miscarriage of the girl for the purpose of preserving her life. He told the jury that they should take a broad view of what was meant by preserving the life of the mother: "[i]f the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequences of the continuance of the pregnancy will be to make the woman a physical and mental wreck, the jury are quite entitled to take the view that the doctor, who, in those circumstances, and in that honest belief, operates, is operating for the purpose of preserving the life of the woman"[15]. In 1948, *R v Bergmann and Ferguson*[16] clarified this decision. The judge in this case held that it was not relevant whether Dr Ferguson (the psychiatrist who had certified the need for termination) held a *correct* opinion as to the existence of such grounds for termination, so long as it was *honestly held*. This was emphasised again by *R v Newton and Stungo*: "use of an instrument is unlawful unless the use is made in good faith for the purpose of preserving the life or health of the woman. When I say health I mean not only her physical health but also her mental health. But I must emphasise that the burden of proof that it was not used in good faith is on the crown"[17]. Thus, as long as the doctor acted in good faith, therapeutic abortion was legal. Even from before the Bourne judgment, however, abortions were performed by doctors for therapeutic purposes, according to criteria established by themselves (Keown; 1988; 78). Moreover, provided that practitioners abided by professional ethics, there seems to have been little risk of prosecution[18].

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[15] *R v Bourne* [1938] 3 All ER 615 at 619.

[16] [1948] 1 Brit Med J. 1008

[17] [1958] Crim LR 469; [1958] 1 Brit Med J. 1242.

[18] The bringing of a case against Dr Bourne should not be seen as an exception to this, as he actively courted his prosecution, informing the police of the operation himself and inviting them to arrest him (see Bourne; 1962). Of the four doctors involved in the other two cases mentioned above, the only conviction was of a doctor who was clearly acting outside the terms of what was accepted to be good medical practice.

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The combination of a climate of social reform with very restrictive legislation (and wide variation in medical interpretation of it) formed the backdrop for the introduction of the 1967 *Abortion Act*, which decriminalised the operation of some abortions when authorised and performed by qualified medical practitioners, working within certain guidelines. S.1(1) of the *Abortion Act* provided that an abortion would be lawful if performed by a registered medical practitioner, after two registered medical practitioners have formed a *bona fide* opinion as to the existence of certain circumstances: either that the continuance of the pregnancy would involve risk to the life or physical or mental health of the pregnant woman or that of any existing children of her family, greater than if the pregnancy were terminated; or secondly that there was a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped. Under s.1(2), in determining whether the continuance of a pregnancy would involve such risk of injury to the health of woman or existing children, the doctors may take account of the pregnant woman's actual or reasonably foreseeable environment[19].

2. The Need for Reform

"Britain has been magnificently hypocritical, maintaining that in general abortion is wrong, but fitfully turning a blind eye when the law is interpreted so as to allow abortion for a variety of reasons...the result has been to squeeze the law so hard, and make it look so ridiculous, that reform of some kind is now in sight. The authorities' inability to stop illegal abortion brought the law into contempt for a hundred years..." (Ferris; 1966; 14).

I have argued above that the *Abortion Act* has been widely represented as a permissive measure. Having also given a brief account of the development of the law and the nature of the reform introduced by the *Abortion Act*, I will demonstrate that the aims of the legislation were not primarily permissive (i.e. the law did not aim to provide more space, free from external

[19] These grounds were subject to some amendment in 1990. Notably, a time limit of 24 weeks was introduced, to apply unless termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman, where continuance of pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated, or where there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities to be seriously handicapped.

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intervention, where women could exercise a greater degree of sexual and reproductive autonomy). I will not attempt to provide a unitary account of the motivations of all who sought reform. The *Abortion Act* represents the outcome of struggles between different groups expressing competing interests and opinions, and it is important to recognise the vital role of women's campaigning groups (such as the *Abortion Law Reform Association*). However other factors were also important: the pressure exerted by medical groups, concern at the widespread flouting of the law, the contribution of illegal abortions to high figures of maternal mortality, a related concern for the effect on the family and an unequal application of the law (with a thriving private sector in the provision of abortion) all contributed to a desire for reform. The reasons underlying reform were thus many and various. What I want to achieve here is a shift of balance or focus between these different factors. Below I group the motivations for reform which I believe to have been the most important into two major categories - factors relating to the protection of medical discretion and autonomy and a desire to bring women out of the backstreets and into contact with their GPs. The former of these has already received some attention (see especially Keown; 1988) and so will be covered only briefly here. The latter has, I believe, been largely neglected.

a) Protection of Medical Autonomy and Discretion

A first category of concerns which influenced the development of the *Abortion Act* was the desire to entrench and protect medical autonomy and to delineate a space for the exercise of medical discretion. Groups representing the interests of the medical profession exerted considerable influence on the development of the *Abortion Act* (as indeed they have done with earlier and later abortion legislation)[20]. Keown notes that none of the major medical bodies opposed reform as

[20] For more discussion of the impact of the medical profession on the development of abortion law from 1803-1982, see Keown (1988). Keown argues that their influence was considerable and was apparent in the gradual statutory restriction of laws against abortion from 1803 to 1861, which reflected (in part) the medical profession's condemnation of abortion and its recommendations for reform. Further, the influence of the medical profession is clearly apparent again in the shaping of the *Abortion Act*, and in defending it from subsequent threat of restriction. In the Act, the profession succeeded not only in entrenching its traditional autonomy over the recommendation and performance of abortion, but also in extending it.

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such, but the profession was firmly opposed to any reform which compromised clinical freedom either by taking the final decision out of the hands of the doctor or by specifying the indications for abortion too exactly (1988; 87). In the late 1960s, many prominent members of the medical profession were opposed to what they saw as the intrusion of the law into the sphere of medical power. Moreover, the situation of semi-legality of many abortions left them in a position of uncertainty with regard to potential prosecution (see Ferris; 1966). There was also a feeling of anger and resentment amongst many that whereas some doctors desisted from performing any abortions, their colleagues in the higher echelons of the profession collected large fees for doing so.

i) Restriction of professional autonomy

There had long been resentment within the medical profession that the law should restrict their freedom to act in what they perceived as the best interests of their patients. John Keown (1988) provides a detailed account of the influence of the medical professional bodies on the formulation of the 1967 Act. He argues that the desire to protect professional autonomy was central to the position adopted by the various groups. This led medical profession to call for the law to ensure the elimination of abortion by untrained and 'unskilled personnel'[21] and to oppose any rigid codification of the indications for abortion which might lead patients to expect a right to termination where given circumstances were met.

ii) Fear of prosecution

As was noted above, there seems to have been very little real risk of prosecution of a qualified medical practitioner who performed abortions prior to 1967 so long as he/she acted in conformity with medial procedure. This was especially true after the case of *R v Bourne* had clarified the operation of the law. However, as Hindell and Simms (1976; 14) relate, for the medical

[21] See the 1966 report of the Medical Women's Federation (Keown; 1988; 95).

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profession the law remained both fragile and ambiguous, granting only "a tenuous and ill-defined right to induce abortion"[22]. It was fragile in the sense that Macnaghten seemed to have carried the law far beyond the intention and the letter of the statutes, and because his decision was made in a lower court and might have been overruled if a case went to appeal. And it was ambiguous because much seemed to rest on whether the doctor could establish that he had terminated a pregnancy in good faith and that it was his honest opinion that unless he had done so the consequences would have been grave. Many practitioners remained reluctant to carry out terminations for fear of prosecution (Harvard; 1958, Ferris; 1966). Harley Street doctors would take precautions to 'cover their backs', obtaining a second opinion, normally from a psychiatrist who would testify to the effect of continuing a pregnancy on the woman's mental health. Other less wealthy doctors would operate in semi-clandestinity. They may have sometimes have felt restricted from charging those fees they would have liked, given that to demand a very high fee might also be taken as a sign of bad faith (Ferris; 1966, Harvard; 1958; 609).

iii) 'Legal', private abortions

Large numbers of abortions of dubious legality were occurring in the private sector, for those women who could afford them (Jenkins; 1960, Ferris; 1966, Greenwood and Young; 1976, Hindell and Simms; 1971). In her minority opinion to the Birkett Report, Dorothy Thurtle noted that it was not difficult "for any woman of moderate means to find a medical man willing to relieve her of an unwelcome pregnancy regardless of the state of her health." (Brookes; 1988; 124). It was believed that around 20,000 'legal' abortions were performed in the private sphere each year by the early 1960s, and it seems that they were available to any woman who had a certain amount of persistence and the necessary 100 or so guineas to pay for one[23]. This

[22] Royal Medical Association's memorandum on therapeutic abortion (1966), cited in Hordern and Brudenell (1971; 9).

[23] Although the price could rise even higher than this. Ferris notes that: "where the surgeon considers that a woman, her husband or her lover can afford more, the fees go up. Hearsay puts them as high as £400 or £500, though the highest I heard anyone admit to was £250 - 'If they can afford to pay,' he said, 'I have no hesitation in jacking up my fee'" (Ferris; 1966; 103).

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provoked allegations of social inequality in the operation of the law[24]. For example, Kenneth Robinson said in introducing his own (failed) attempt to reform the law in 1961: "[i]t is a perfectly simple matter for anyone who has sufficient money to get a pregnancy terminated today by a qualified medical practitioner on the flimsiest of medical grounds...This leads in the simplest possible terms to a situation in which there is one law for the rich and one law for the poor. If there were no other arguments for amending the law, I submit that is a very powerful one"[25]. This perceived social inequality and failure to prosecute senior obstetricians and gynaecologists who collected large fees for performing terminations, also provoked resentment amongst their more junior colleagues. One doctor told the Birkett Committee that "patients for whom I have without difficulty refused to evacuate the uterus have had the operation performed in London" (Simms; 1980; 1).

b) Bringing Women From the Backstreets to the GP's Surgery

i) Reducing maternal mortality

The major aim of the pressure group most active in pushing for reform was to bring some relief to the suffering of those women who experienced unwanted pregnancy. The formation of the Abortion Law Reform Association in 1936[26] had been provoked by the plight of women who had previously faced risky back street abortions, and who had often suffered serious physical complications as a result of having them. Official estimates showed that 35-40 women died each year as a result of botched abortions, but unofficial sources guessed at a far higher figure[27]. The

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[24] For example, the telling title of Alice Jenkins' (1960) book on abortion: *Law for the Rich.*

[25] Robinson, H.C. Deb. Vol. 634 Col. 858, 1961.

[26] For an account of the formation of the ALRA, see Jenkins (1960), Hindell and Simms (1971), Greenwood and Young (1976) and Brookes (1988).

[27] Ferris argues that many death certificates were disguised to conceal abortions in order to protect the good name of the family (Ferris; 1966; 73-5). The Birkett Committee quoted figures of 411-605 deaths per year associated with abortion (this also includes non-criminal terminations).

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partial decriminalisation of abortion was thus an essential step in the progression towards a more enlightened, humane and sympathetic approach to the situation of women facing unwanted pregnancy and a recognition that, in certain circumstances, it is cruel and unreasonable to expect women to carry that pregnancy to term. The Parliamentary debates preceding the introduction of the 1967 Act are littered with tragic examples of women who have died either during illegal abortions or as a result of being forced to continue with an unwanted pregnancy, and who leave families behind them. A particularly distressing account is given by Lena Jeger MP, who relates the story of an "honest young woman" who was refused a termination on the grounds that "she did not seem quite depressed enough". Forced to continue with the pregnancy, the woman's depression following the birth of the child was so great that she killed it. She was sent to Holloway prison, and her other five children were put into care[28]. The desire to improve the situation of women facing unwanted pregnancy was not translated into a desire to give women greater autonomy, however. Rather, these women were not seen as sufficiently stable or rational to make important reproductive decisions. Whilst the reformers believed that women seeking abortion had been wrongly stigmatised as criminals, they represented them as victims who needed help and guidance (Sheldon; 1993).

The difficulty of legally terminating a pregnancy was implicated in the sustaining of high maternal mortality figures, which had consistently refused to improve in line with other health statistics. Indeed, by 1966 illegal abortion had become the chief cause of avoidable maternal death (Brookes; 1988; 133, Oakley; 1984) at a time when four women in a thousand died for reasons relating to maternity (Jenkins; 1960; 47). According to Mason (1990; 105), pathologists of the period taught that in cases of the unexpected death of a young woman, pregnancy should be suspected until its existence was positively disproved. Recognition of this problem was not

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Dickens puts the number of deaths from criminal abortions in excess of 200 per year (Dickens; 1966; 113) and Williams hints at a still higher figure (1958; 194).

[28] Jeger, H.C. Deb, Vol. 749, Col. 977-8, 1967 (29 June). For other such cases, see Sheldon (1993).

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new to the 1960s, however. As long ago as 1935, the first woman MP, Lady Astor, had told the House of Commons that: "a high percentage of maternal mortality is due to attempted abortion...We, as a House of Commons and as a Nation, must face up to that fact today" (Simms; 1980; i)[29]. It was these same concerns for maternal mortality which led to the establishment of the Birkett Committee in 1939. Its brief was: "to inquire into the prevalence of abortion and the present law relating thereto and to consider what steps can be taken by more effective enforcement of the law or otherwise to secure the reduction of maternal mortality and morbidity arising from this cause" (Brookes; 1988; 105)[30].

ii) The threat to the family

The related threat to the family was another powerful argument for reform. Many examples are given in the Parliamentary Debates of cases where the family had suffered as a result of losing the wife/mother who was its central focus and binding force. The abortion reformer, Joan Malleson wrote: "it happens that with the invalidism or death of these mothers, the family disintegrates; for around their health and their capacity to tend the children the whole home revolves: and therefore these mothers are the very last who should be permitted to jeopardize their well-being" (1938, cited in Jenkins; 1960; 37). This loss of mother/wife might result from the woman's death following unsafe, illegal abortion. It also might result from the suicide of the woman faced with an unwanted pregnancy, and Alice Jenkins discussed several such cases in her

[29] A much cited paper, published in the same year, reached the same conclusion: "[a]bortion is increasing in frequency, and the chief factor responsible for subsequent morbidity and mortality is illegal interference with pregnancy, the interference being usually determined by poverty. The law has failed to prevent the self-induction of abortion, and the problem, which is one of preventive medicine, must be reviewed from this aspect, consideration being given to the changed economic and social conditions of the present day." (Parish; in Simms; 1981; 175).

[30] This followed directly from the 1937 Report on Maternal Mortality which had recommended the further study of various subjects including "abortion with special reference to the influence which it may exert on maternal mortality and morbidity and future childbearing" (Brookes; 1988; 105).

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influential book (1960; 76-7)[31]. Equally, the effective 'loss' of the mother might be caused by the additional strain which she faced in having another child. As Dr. John Dunwoody told Parliament: "my belief is that in many cases today where we have over-large families the mother is so broken down physically and emotionally with the continual bearing of children that it becomes quite impossible for her to fulfill her real function, her worthwhile function as a mother, of holding together the family unit, so that all too often the family breaks apart, and it is for this reason that we have so many problem families in many parts of the country"[32]. David Owen outlines the same problem - the woman facing an unwanted pregnancy is "in total misery, and could be precipitated into a depression deep and lasting. What happens to that woman when she gets depressed? She is incapable of looking after those children, so she retires into a shell of herself and loses all feeling, all her drive and affection"[33]. Even Jill Knight, the ardent and vocal opponent of abortion recognised the woman's central role in the family: "if it comes to a choice between the mother's life or the baby's, the mother is very much more important, she has ties and responsibilities to her husband and her other children"[34].

iii) Back street abortions: a consistent flouting of the law

Dickens concludes his (1966) book on abortion and the law with the assertion that: "[i]t is generally accepted that the law relating to abortion is widely disregarded, and that stricter enforcement would be difficult, and not necessarily a deterrent when women are desperate, and prepared, if no help is available, to operate upon themselves with instruments or drugs. Legal sanctions do little more than provide an abortionist with incentives to avoid detection, and so drive the offence underground to an extent where a small fragment of 1 per cent of abortionists

[31] In the House of Lords Debates, Lord Strange argues that "nearly every woman in this condition [of unwanted pregnancy] would be in a state bordering on suicide." (Strange, H.L. Deb. Vol. 277, Col. 1235, 1966 (23 October).

[32] H.C.Deb. Vol. 732, Cols. 1098-9, 1966 (22 July).

[33] Owen, H.C. Deb. Vol. 732, Col. 1115, 1966 (22 July).

[34] Knight, H.C. Deb. Vol. 732 Col. 1104, 1966 (22 July).

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is detected. On the other hand illegal abortion is associated with deaths counted in hundreds each year, and causes ill-health and serious damage to many women. Modest estimates of illegal operations range between 50,000 and 100,000 annually, and the figure of a quarter of a million has authority. *It may appear that the present law drives abortion into the most undesirable and dangerous channels, without eliminating it*" (Dickens; 1966; 165 - my italics).

Dickens' book is symptomatic of the widespread agreement which had been reached by the late 1960s, that the regulation of abortion was a failure. This was not measured entirely - or even primarily - in humanitarian terms, but rather in functionalist ones: the regulation was unpopular, ineffective and constantly flouted. As such, an important reason advanced for the partial decriminalisation of abortion in the UK was the need to take control of a situation of mass de facto female resistance, where "the administration of the law has broken down [and] it is neither respected nor obeyed"[35]. The Birkett Committee reported in 1939 that: "[w]e are satisfied that the law in this matter is freely disregarded among women of all types and classes." Speaking thirty years later to the House of Commons, Roy Jenkins, then Home Secretary, was in agreement. He argued that the present regulation was unable to deal with the problem. A decriminalisation would serve to bring unwanted pregnancy and abortion within the ambit of a medical control, where it might thus be more effectively monitored: "the existing law on abortion is uncertain and is also, and perhaps more importantly, harsh and archaic and...is in urgent need of reform...How can anyone believe otherwise when perhaps as many as 100,000 illegal operations per year take place, that the present law has shown itself quite unable to deal with the problem?...the law is consistently flouted by those who have the means to do so...it causes many otherwise thoroughly law-abiding citizens to act on the fringe, or perhaps on the wrong side of the law. As the Minister responsible for law enforcement, I believe that to be a thoroughly bad thing"[36].

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[35] McNamara, H.C. Deb. Vol. 732, Col. 1124, 1966 (22 July).

[36] Jenkins, H.C. Deb. Vol. 732, Cols. 1141-2, 1966 (22 July).

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Media reporting and the growth in public awareness had made it increasingly hard to ignore the occurrence of widespread illegal abortions and the thalidomide tragedies of the early 1960s had contributed to the creation of a greater public sympathy for women seeking to terminate pregnancies. It was impossible to judge accurately how many abortions per year were performed, but estimates ranged from 10,000 to 250,000 (Dickens; 1966; 73)[37]. Indeed, according to Jane Lewis, working class women viewed abortion as a natural and permissible strategy (1984; 17). The Birkett Committee found that "many mothers seemed not to understand that self-induced abortion was illegal. They assumed it was legal before the third month, and only outside the law when procured by another person" (cited in Lewis; 1984; 17).

Prosecutions represented just the very tip of the iceberg[38], with convictions numbering an average of around 50 per year (Williams; 1958; 192). The practice of prosecuting only the abortionist and not the pregnant woman was long established (Williams; 1958; 146)[39]. As with all 'victimless crimes', offences were hard to detect. The police were largely tolerant of the activities of abortionists unless they were forced to act - for example, if a woman died during or following an abortion (Simms; 1980; 5) or where she was brought to the hospital with serious complications such as a septic abortion or perforated uterus. From their point of view, abortion cases were time consuming and awkward, since the pregnant woman, who was generally required as a witness, was naturally reluctant to bring evidence against the abortionist who had relieved her of an unwanted pregnancy (Hindell and Simms; 1971; 37, Brookes; 1988; 133, Jenkins; 1960;

[37] The Birkett committee estimated 54,000 p.a. (Jenkins; 1960; 33), Hordern (1971; 2) says 120,000-175,000.

[38] There were 62 prosecutions for illegal abortions in England and Wales in 1966, 28 of which resulted in prison sentences (Mason; 1990; 105) and 71 in 1967 (Cavadino; 1976; 63). As Glanville Williams points out, this represents less than one prosecution for every 1,000 criminal abortions.

[39] See the case of *R v Mills* [1963] 1 QBD 522, [1963] 1 All ER 202, following *R v Scully* (1903) 23 NZLR 380. See also *Peake* (1932) 97 JPN 353.

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33-4)[40] and the public were often unwilling to help with enquiries. David Steel, in introducing the *Abortion Act*, cites the case of a 24 year old woman found dying in a North London street following an illegal abortion. He quotes from the *Evening Standard*: "After hearing from the police that they had been unable to find out where the abortion took place, the St. Pancras coroner said: 'We are up against a blank wall of unwillingness to know and unwillingness to talk'". Ferris cites several interviews with police officers who spoke of their reluctance to prosecute abortionists. One superintendent told him: "we know there's lots going on, but we don't prosecute unless we're forced to" (1966; 92). Ben Whitaker in his (1964) book, *The Police* writes of the same phenomenon: "some police, particularly in poorer areas, have a certain amount of sympathy for the altruistic abortionist, and tend to ignore his activities unless some tragedy or trouble occurs" (in Dickens; 1966; 77). In the rare cases where charges were brought, popular sympathy with the plight of the woman made juries unwilling to convict.

Many of the backstreet abortionists commanded huge popular support, especially where they were known to have acted through sympathy for the woman rather than for financial gain (Ferris; 1966; 88, Simms; 1981; 179, Brookes; 1988; 140). Simms reports that the funeral of Dr Daniel Powell of the High Street, Tooting was attended by women from all parts of the country. When Dr Powell had been prosecuted, his patients had collected the money for his defence. One detective who had been on his trail for some years, said: "he was a great hearted and fearless man whose work was directed by the highest motives" (Simms; 1981; 173-4). Hindell and Simms (1971; 38-9) likewise relate the case of William Tellam, who was sentenced to three years' imprisonment for carrying out illegal abortions in his surgery. Instead of being regarded as a villain, Tellam was a kind of hero figure, and eighteen thousand people signed a petition asking for clemency in his case. Dora Russell wrote in *The Guardian* that: "[o]ur inhuman and obsolete law against abortion has now claimed a fresh victim in one of the best and ablest

[40] As one police officer related: "it is gratitude to the person who has relieved them of an unwanted burden that keeps the victims of abortion silent. For this type of help, gratitude wells up in the heart to subdue every other sense. Even when dying they hug their secret gratefully, refusing to divulge the name of the person who has brought them to this impasse" (Williams; 1958; 190).

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medical men practising in Penzance...It is tragic that even a skilled practitioner who comes to the help of women pregnant and desperate, is liable to disgrace and punishment" (Hindell and Simms; 1971; 39). Brookes reports several other cases where patients collected petitions in support of doctors convicted for performing abortions[41].

In such a climate of mass illegality and popular resistance to enforcement of the law, a partial and controlled decriminalisation of abortion had much support in Parliament. Even the staunchest opponents of the abortion agreed that some kind of reform was needed[42]. No doubt this was inspired in part by compassion for the plight of the woman, but more important was the clear need to bring this situation of widespread illegality under control. Steel, in introducing the second reading of his Bill, emphasised that: "[w]e want to stamp out the back street abortions, but it is not the intention of the Promoters of the Bill to leave a wide open door for abortion on request"[43]. The *Abortion Act* aimed to abolish backstreet abortion by granting registered medical practitioners a legal monopoly on the termination of pregnancy (Keown; 1988; 159). This would install the medical profession as the gatekeepers or parallel judges who could grant or refuse access to termination according to how deserving an individual case was felt to be. Importantly, it would also enable abortion to be located it in hospitals where it could be monitored, and make possible a system of registration whereby details of the woman and the reasons for allowing her abortion could be registered. Moreover, to decriminalise abortion in controlled circumstances would make it visible and enable its incidence to be mapped. 'Liberalisation' was thus proposed and accepted (at least in part) to bring under control a situation of mass illegality, and to ensure that the incidence of abortion might be more closely

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[41] 10,000 patients signed in support of Dr Sumatapalage Gunewardene (when he was sentenced to three years imprisonment for being an accessory to an abortion which resulted in death); 2,739 signed in support of Dr Charles Bikitsha; and 1,100 for Dr Hanratty (Brookes; 1988; 140-1).

[42] See Wells, H.C. Deb. Vol. 732, Col. 1080, 1966 (22 July); Deedes, H.C. Deb. Vol. 732, Col. 1091, 1966 (22 July); Hobson H.C. Deb. Vol. 732, Col. 1132, 1966 (22 July); Braine, H.C. Deb. Vol. 747, Col. 455, 1967 (2 June).

[43] Steel, H.C. Deb Vol. 732, Col. 1075, 1966 (22 July).

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monitored.

3. The Perceived Benefits of Reform

The model of legislation adopted in the *Abortion Act* clearly reflects those aims which are discussed above. The *Abortion Act* would permit women seeking termination to be brought under a closer medical control, safeguard medical autonomy and discretion, and at the same time render abortion visible and enable it to be monitored and mapped by way of a system of registration, and provisions regulating where terminations might be performed.

a) Bringing women under medical control

The *Abortion Act* is fundamentally underpinned by the idea that reproduction is an area for medical control and expertise and that the doctor is the most appropriate expert to deal with abortion. This reflects not merely a belief in his/her technical expertise, but also the notion that the doctor is in the best position to observe the woman, and take charge of her situation. Moreover, the doctor is seen as taking on many of the pastoral functions previously associated with the priest: he is a guardian of the social body and a bastion of moral values[44]. Peter Mahon M.P. reminds the House of Commons that: "it would be as well if we applauded the work of some of these men to keep our homes and families and the country right"[45]. The *Abortion Act* accords clear moral authority to the doctor, in that it is he/she who has the final decision regarding abortion. There is nothing commonsensical about the decision to grant such

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[44] This function of the doctor as a source of moral authority is detailed by Foucault in both *Madness and Civilisation* and *Birth of the Clinic*. In the former he notes that the introduction of the doctor into the asylum was based more on his moral authority than on his medical knowledge: "his absolute authority in the world of the asylum...insofar as, from the beginning, he was Father and Judge, Family and Law - his medical practice being for a long time no more than a complement to the old rites of Order, Authority and Punishment" (1989a; 272, See also Foucault; 1980a).

[45] Mahon, H.C. Deb. Vol. 747, Col. 502, 1967 (2 June).

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power to doctors (medical experts), when one remembers that the vast majority of abortions are desired for social rather than medical reasons. The power given to doctors here far exceeds that which would accrue merely on the basis of a technical expertise.

A very clear construction of the typical doctor appears within the debates which stands in strong contrast to the figure of the pregnant woman who is seen as a marginal and irrational figure (see Sheldon; 1993). The doctor is a male figure[46] who is perceived as the epitome of maturity, common sense[47], responsibility and professionalism. He is a "highly skilled and dedicated"[48], "sensitive, sympathetic"[49] member of a "high and proud profession"[50], which acts "with its own ethical and medical standards"[51] displaying "skill, judgement and knowledge"[52].

It was hoped that mere contact with this responsible and reassuringly male figure might dissuade the woman from abortion - the need for an abortion often being posited here as a direct consequence of her own hysteria and derangement, rather than a rational decision reflecting a reasoned assessment of her concrete situation. The rule of the doctor would be one of

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[46] Doctors are referred to as "medical men", "professional medical gentlemen" and "professional men". They are always referred to as "he" within the 1966-7 debates. William Deedes notes that "the medical profession comprises a great diversity of men" Deedes, H.C. Deb. Vol. 732, Col. 1092, 1966 (22 July); and Jill Knight says that "the GP is a skilled man" H.C. Deb. Vol. 747, Col. 482, 1967 (2 June) See also, Knight, H.C. Deb. Vol. 749, Col. 931, 1967 (29 June). Jenkin, H.C. Deb. Vol. 749, Col. 967, 1967 (29 June); Hobson, H.C. Deb. Vol. 747, Col. 531, 1967 (2 June); Hogg, H.C. Deb. Vol. 747, Col. 946, 1967 (2 June).

[47] Steel, H.C. Deb. Vol. 747, Col. 463, 1967 (2 June)

[48] Mahon, H.C. Deb. Vol. 750, Col. 1352, 1967 (13 July)

[49] Raglan, H.L. Deb. Vol. 274, Col. 591, 1966 (10 May)

[50] Lyons, H.C. Deb. Vol. 732, Col. 1090, 1966 (22 July)

[51] Steel, H.C. Deb. Vol. 747, Col. 464, 1967 (2 June).

[52] Hobson, H.C. Deb. Vol.747, Col. 531, 1967 (2 June).

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responsible control[53]. This point is made repeatedly in the Parliamentary Debates, for example in my opening citation from David Steel: "if we can manage to get a girl such as that into the hands of the medical profession, the Bill is succeeding in its objective"[54]. Steel picks up on this same argument in the Parliamentary debates at the time of Human Fertilisation and Embryology Act (1990), where he relates that doctors have told him that they now have the chance to see women before they abort and to discourage them from doing so. One told him that: "[o]ne of the effects of the 1967 legislation has been that people will come to his surgery and discuss abortion with him, whereas pre-1967 they would not have done so and he would have lost control of what was happening, and the patient might have ended up with a back-street abortion or going into a private clinic"[55]. David Owen echoes the same sentiment later in the 1966-7 debates, noting that "[i]f we allow abortion to become lawful under certain conditions, a woman will go to her doctor and discuss with him the problems which arise...he may well be able to offer that support which is necessary for her to continue to full term and successfully to have a child"[56]. The same argument also arises in the academic literature, with Glanville Williams asserting that: "[a]n important medical result of legalizing abortion would be that it would enable the patient to take proper professional advice. It is, of course, always open to a doctor to dissuade his patient from the operation by pointing out any harmful effects that he thinks it may have" (1958; 203-4).

b) Medical Autonomy

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[53] For example, Steel, H.C. Deb. Vol. 732, Col. 1076, 1966 (22 July); H.C. Deb. Vol. 750, Col. 1348, 1967 (13 July); Owen, H.C. Deb. Vol. 732, Col. 1116, 1966 (22 July); Dunwoody, H.C. Deb. Vol. 732, Col. 1096, 1966 (22 July).

[54] Steel, H.C. Deb. Vol. 750, Col. 1349, 1967 (13 July).

[55] Steel, H.C.Deb. Vol. 171, Col.210, 1990 (24 April).

[56] H.C. Deb. Vol. 732, Col. 1116, 1966 (22 July). See also Steel, H.C. Deb. Vol. 732 Col. 1076, 1966 (22 July). Bernard Dickens makes the same point as an argument for reform (1966; 133).

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The law aims to protect medical autonomy and discretion rather than to grant substantive rights to the woman, even where she is in the most extreme circumstances envisaged by the reformers. The severely depressed mother of five, described by Lena Jeger (see above), would still have no right to a termination. Rather, the regime introduced by the *Abortion Act* offers the qualified doctor (and only derivatively his/her patient) a valid defence against s.58 *Offences Against the Person Act* for certain terminations, where these have been medically authorised and performed[57]. This is important in that the law serves to grant woman and doctor together some rights against the State, but grants the woman no right to privacy or autonomy vis-à-vis the doctor. The decriminalisation of abortion entrenched the doctors' control of abortion and marked the legal recognition of the era of the doctor-judge who could administer, and exercise power more quickly and effectively than a state-centred apparatus.

The clear desire to avoid giving any substantive rights to women is most clearly illustrated by the debates centring around whether the *Abortion Act* should carry a 'social clause' (whereby the need for abortion might be established with regard to socio-economic factors), and a clause allowing abortion in case of rape or incest. Steel's original *Medical Termination of Pregnancy Bill* did carry such clauses, s.1(c) allowing doctors to authorise abortion where: "the pregnant woman's capacity as a mother will be severely overstrained by the care of a child or of another child as the case may be" and s.1(d) where "the pregnant woman is a defective or became pregnant while under the age of sixteen or became pregnant as a result of rape". These clauses were, however, opposed by all of the major medical bodies, who felt that women might interpret them to mean they had a *right* to demand abortions where the circumstances outlined were met (Keown; 1988; 87). For example, the Royal Medico-Psychological Association warned that: "[s]pelling out in detail when a doctor should or should not have the right to induce abortion, even if the legislation is cast in permissive terms, would have the effect of introducing an element of coercion in the sense that in each defined situation the patient might reasonably expect

[57] Thus, s.1(1) provides that "a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion formed in good faith" [that certain conditions are fulfilled].

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the doctor to acquiesce and the role of the surgeon or gynaecologist would be reduced that of a technician carrying out an objectionable task" (Keown; 1988; 89)[58].

As a result of pressure from medical groups, the two clauses were subsequently removed. It was argued that in case of rape or incest abortion would already be available under other provisions, notably the risk to the woman's mental health. To remove the clause would mean that women would not feel they had an automatic right to termination in these circumstances, and would minimise the risk of their fabricating stories of rape in order to qualify for abortion[59]. The social clause was removed and was replaced with a wording which, whilst allowing social and economic factors to be taken into account, made it absolutely clear that the decision remained with the doctor. Thus, under s.1(2), the doctor is now authorised in determining whether continuance of pregnancy would involve such risks to life or to mental and physical health as are specified in s.1(1), to take account "of the pregnant woman's actual or reasonably foreseeable environment"[60]. This ensures that socio-economic factors are assessed only in so far as they are subject to evaluation by a doctor and that the doctor, rather than the woman herself, thus

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[58] See Keown (1988) for the same objections from all the other major medical bodies: the British Medical Association (90); the Royal College of Obstetricians and Gynaecologists (93); and the Medical Women's Federation (95). That a doctor should not be forced to carry out a termination when he/she does not wish to do so is also enshrined in s.4 of the *Abortion Act* which provides for the possibility of conscientious objection to providing treatment under the *Abortion Act* except when the operation is necessary to save the woman's life or to prevent grave, permanent injury to her health.

[59] The idea that the women might fabricate charges is put forward several times in the Parliamentary Debates (see Sheldon; 1993; 18), and also in the Birkett Report which suggested that in a great number of cases, "girls and women made the allegation of rape falsely" (Brookes; 1988; 117).

[60] Compare this with the formula put forward by the Royal College of Obstetricians and Gynaecologists who suggested that the law might also provide that the practitioner could take into account such circumstances, whether past, present or prospective as were in the doctor's opinion relevant to the physical or mental health of the woman or of the child if born (Keown; 1988; 92) and the joint report of the Royal College of Obstetricians and Gynaecologists and the British Medical Association which argued for a subclause which had almost exactly this wording (Keown; 1988; 97).

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remains the ultimate judge even with regard to such factors.

c) The possibility to monitor the incidence of abortion: notification and regulation of premises where terminations might be performed

Another perceived advantage to the strict medical control of abortion was that it might be made more visible and hence more subject to control. S.1(3) of the *Abortion Act* provides that any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State, or in a place approved by either for the purposes of the section[61]. Henceforward, abortions would be performed only in hospitals or specially licensed premises. The *Abortion Act* also paved the way for a system where doctors might be made responsible for notifying the performance of abortions, so that their incidence might be better measured and recorded. It includes a strict regime of notification which allows the monitoring of abortion. Under s.2, there is a duty for the Minister of Health (or the Secretary of State for Scotland) to ensure that any practitioner who terminates a pregnancy must provide to the Ministry of Health (or Scottish Home and Health Department) "such notice of the termination and such other information relating to the termination as may be so prescribed". Under s.4(1) of the Abortion Regulations[62], the operating practitioner is required to notify the abortion to the Chief Medical Officer, within seven days. This makes possible the yearly publication of statistics by the OPCS recording the number of abortions, reasons for performing them, the number of foreign women having abortions in the UK, the method of abortion, the number of weeks of gestation, whether women are married or single, how many children they have already, whether the

[61] S.1(4) provides that this restriction shall not apply when a registered medical practitioner is of the opinion, formed in good faith that termination is immediately necessary to save the life, or to prevent grave, permanent injury to the physical or mental health of the pregnant woman. S.1(3) was amended in 1990 to allow the relevant authorities to approve simultaneously a "class of places" for the performance of terminations. This would seem to have been done with the possibility of licensing other premises for the purposes of (one stage of) antiprogesterone terminations.

[62] Originally, SI 1968 no. 390, issued the same day as the *Abortion Act* came into force. Currently governed by SI 1991 no. 499.

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abortions are performed on the NHS or in private clinics etc. Moreover, these statistics enable comparisons with similar foreign data. A 'dark mass' of unknowable female criminality is brought into the open and isolated in the bodies of individual women. The problem of abortion is changed from one of widespread and unquantifiable *deviance*, to one of isolated and identifiable, individual *deviants*.

4. Conclusions

"I don't want to say that the State isn't important; what I want to say is that relations of power, and hence the analysis that must be made of them necessarily extend beyond the limits of the State...because the State for all the omnipotence of its apparatuses, is far from being able to occupy the whole field of actual power relations, and further because the State can only operate on the basis of other, already existing power relations. The State is superstructural in relation to a whole series of power networks that invest the body, sexuality, the family, kinship, knowledge, technology and so forth" (Foucault; 1980c; 122).

In this paper, I have marked a shift in the modality of State attempts to bring women seeking to terminate pregnancies under control. Here focusing on the aims of the *Abortion Act*, I have taken issue with the common representation of that law as an essentially permissive measure which envisages a loosening of power over abortion, reproduction and (women's) sexuality. In such a light, the *Abortion Act* has been seen as both interpretative and constitutive of the development of a private sphere where sex may be enjoyed free from public interference and regardless of the (lack of) procreative intention of the participants. I have challenged this representation in arguing that whilst the *Abortion Act* has undoubtedly facilitated women's access to safer, legal terminations, it also represented a strategical and pragmatic move on the part of the State to increase its control over a situation of widespread illegality and to implement a more subtle deployment of power over women and this 'private sphere' of sexuality. Women's sexuality has in one sense been rendered more, not less, visible by the passing of the *Abortion Act*, in that their 'private' sphere of action is now open to extensive examination by doctors.

The problematisation of the connection between seemingly humanising reform and a loosening

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of power which has underpinned this paper owes much to the work of Michel Foucault. Foucault has written that the reduction in penal severity in the last 200 years has long been regarded in an overall way as a quantitative phenomenon: "less cruelty, less pain, more kindness, more respect, more 'humanity'" (1991). He argues, however, that these changes are also qualitative in nature, representing a new - more efficient - strategy in the deployment of power. One might also think here of Foucault's (1979) work on 'governmentality', and the emergence of 'the population' as the new target of government. This ushered in new forms of control aiming less at sporadic and spectacular interventions, and more at a fine and continuous surveillance and modification. An important aspect of the modern era, for Foucault, is the proliferation of small-scale 'legal' systems or parallel judges - of psychiatric and psychological experts, educationalists and members of the prison service - all fragmenting and sharing in the power to punish.

It is my contention that the passing and subsequent operation of the *Abortion Act* can be viewed as part of this process. The *Abortion Act* undoubtedly served in one way to lessen a particular modality of direct State control over abortion, by taking certain terminations out of the ambit of control of the criminal courts[63]. However, in the same process, indirect (medical) control was greatly enhanced and power was extended over the woman's 'private' sphere of action. Through the *Abortion Act*, the doctors, as 'parallel judges', are officially accorded the power to judge the woman and then to decide whether she should have the possibility of an abortion, or whether she should be denied relief and made to face the 'punishment' of being forced to continue with an unwanted pregnancy. Within the regulations introduced by the *Abortion Act*, women are decriminalised in order to be pathologised[64], they are to be judged not by the judiciary but by the 'parallel judges' of the medical profession. The partial decriminalisation of abortion envisaged a finer deployment of power by way of a colonisation of existing lines of medical control and a legitimation, entrenchment and extension of those lines. Further, there is an attempt to make

[63] Although, as has been seen above, attempts to prevent or control abortions by way of the criminal law had proved a visible failure.

[64] See Sheldon (1993) for some examples of the way in which the figure of the woman seeking abortion is 'pathologised' and constructed as in need of normalising medical control.

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use of these lines, by way of the notification procedure and the control of premises, to monitor the incidence of abortion[65].

How far then is the *Abortion Act* a 'permissive' law? And, recalling Disraeli's words that "permissive legislation is the characteristic of a free people", how far does it symbolise a new degree of freedom for women? There can be no doubt that the *Abortion Act* is a piece of permissive legislation if "permissive" is interpreted to mean the carving out of a sphere of freedom from direct and repressive criminal law controls. In this sense the *Abortion Act* does fit within the first part of the OED's definition cited at the beginning of this paper: "having the quality of permitting or giving permission; that allows something to be done or to happen; not forbidding or hindering". The *Abortion Act* is permissive in providing doctors (and derivatively women) with the possibility to terminate a pregnancy without fear of prosecution. This has opened the way to safer, legal terminations. However, it is fitting the *Abortion Act* into the second part of the definition given by the OED which becomes more problematic: "in modern use *freq.*: tolerant, liberal, allowing freedom, *spec.* in sexual matters". The question which is then raised is how far and in what sense the *Abortion Act* gives women freedom in sexual (and I would add in reproductive) matters? This in turn raises a more fundamental question: what do we mean by freedom? Is freedom just the space left by the absence of restrictive criminal controls? The more expansive definition of power which I have outlined would imply an answer in the negative as it would point to the need to take account of medical control over women within the 'private' sphere. If the *Abortion Act* is seen as representing not a lessening of control, but rather a shift in the modalities of control towards a finer means of deploying power, the kind of freedom which women can exercise under it becomes more problematic.

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[65] In terms of the *effects* of the legislation, this attempted colonisation of medical lines of control was in many ways unsuccessful. It seems likely that the notification procedure is not always taken seriously by doctors; further, beyond ascertaining the existence of good faith, the judiciary are largely unwilling to police medical action under the 1967 Act.

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Postscript

The potential misunderstandings which I have most felt at pains to avoid in the writing of this paper, is a reading of my argument which understands it as hostile to the *Abortion Act*. I hope that I have succeeded in making clear that this is *not* my position - I fully recognise that the *Abortion Act* has directly benefitted a great many women in Britain, and indeed benefits all women there in an indirect way. I think that the reason which I have felt trapped in this way is in itself significant, however, and relates back to the issue of how freedom is to be defined. I believe that my misgivings were related to a tendency to assume a rather linear notion of progress with regard to its assessment of feminist engagement with law. In such a perspective, masculine bias in law is seen as a kind of lingering anachronism - something which has been gradually eroded and (so the story goes) which will continue to be worn down, until the day that perfect equality/gender neutrality is achieved. Such a vision accords with a broader, often unstated view of society, and State power within that society - society is not (yet) perfect, but it is gradually getting better, the standard of living is always rising, people are healthier and wealthier than they were in the past, and the individual is gradually accorded more rights and more liberty as s/he achieves more protection from infringements into her/his private life. For an analysis of the *Abortion Act*, this rather linear concept could only assume that the *Abortion Act* was an improvement, but did not go far enough: the point is now to extend it. For example, Madeleine Simms writes: "the 1967 *Abortion Act* was a half-way house. It handed the abortion decision to the medical profession. The next stage is to hand this very personal decision to the woman herself" (Simms; 1985; 94).

For my analysis of the passage of the 1967 Abortion Act, I need to take issue with this image. If one accepts the linear view of progress and makes a quantitative assessment of the *Abortion Act* (has it, on balance, improved the situation of women?) then I am faced with the problem outlined above: how could I possibly criticise the Act? If one also adopts a qualitative level of assessment, however, then a very different kind of analysis can be attempted, and the *Abortion Act* can be seen as part of a shift in the mechanisms of control over women, rather than a

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straightforward decrease in the extent of such control. My point is thus that a quantitative analysis of the exercise of power over women is insufficient - a element of qualitative assessment is also essential. It is not enough to speak in terms of a reform giving women more or less freedom, one must also look at the quality of that freedom, and the novel kinds of constraints and intrusions which it may bring.

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